Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

All payments collected from the patient are strictly an estimated amount due before insurance claim is filed. Insurance claims are not filed until treatment has been completed. All treatment cost estimates given are calculated to the best of our ability. Estimated patient portion and final amount due may vary due to limitations, exclusions, and other plan provisions to each individual's dental insurance policy. It is the patient's responsibility to understand their insurance benefits and eligibility. The patient is responsible for informing the office of any changes to previous insurance plans and eligibility.

I authorize Lemay Family Dentistry LLC to keep this document on file, the office may use it to represent my consent for filing insurance claims. Unless restricted by my insurance policy, payment of insurance benefits, otherwise payable to me, will be made directly to Lemay Family Dentistry LLC. I authorize release of information relating to these claims. I further authorize release of benefits and/or claim information to Lemay Family Dentistry LLC.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

PLEASE PRINT AND SIGN BELOW

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Patient Name (Please Print) Date

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Patient, Parent, or Guardian Signature